Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4100AGZ	A. BUILDING _____ B. WING _____	C 01/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V N SENIOR CARE INC OF SEVEN HILLS	993 GOLD BEAR DRIVE HENDERSON, NV 89052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility 12/23/10 through 1/6/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for nine Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was eight. Complaint #NV00027215 - The allegation of inappropriate level of care was not substantiated. The allegation of the use of restraints was substantiated. See Tag Y0057. The complaint investigation process was initiated by the Bureau of Health Care Quality and Compliance on 12/23/10. The investigation included: -Observations were made of the resident at the facility. -Interviews were conducted with facility staff and the resident's hospice nurse. -Review of the resident's facility file documentation and hospice clinical notes was completed. -It was determined that the resident was not bedfast; therefore, the facility was not providing an inappropriate level of care.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS4100AGZ	A. BUILDING _____ B. WING _____	C 01/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
V N SENIOR CARE INC OF SEVEN HILLS	993 GOLD BEAR DRIVE HENDERSON, NV 89052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 557	Continued From page 1	Y 557		
Y 557 SS=E	449.262(3)(a) Restriction on Use of Restraints NAC 449.262 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident. This Regulation is not met as evidenced by: Based on observation, interview and record review from 12/23/10 through 1/6/11, the facility failed to ensure restraints were not used on 3 of 9 residents (Residents #1, #2 and #3). Severity: 2 Scope: 2	Y 557		